Assessing the Feasibility and Effectiveness of Training Clinicians in Interpersonal Psychotherapy in Ecuador

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FINAL PROGRESS REPORT
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Project Teams & Personnel:
The Global Mental Health Lab (GMH Lab) team was tasked with providing high quality-capacity building in IPT. IPT master-trainers were Principal Investigator (PI) and Director of the GMH Lab, Dr. Lena Verdeli; and IPT master-trainer, Dr. Bryan Cheng, GMH Lab Director of Research. Administrative and project support was provided by research assistants, Angela Paredes-Montero and Hugo Bautista-Lopez.

Outline of the Executive Summary

A. Context of Implementation of the Project
B. Project Goals
C. IPT Training (didactics workshop and supervision of future providers and supervisors)
D. Knowledge Test Outcomes
E. Preliminary results of supervision and clinical outcomes of IPT training cases

A. Context of Implementation of the Project

A.1. Mental Health in Ecuador

Ecuador's journey in implementing mental healthcare for its host population has been marked by significant challenges and recent advancements. Historically, the country faced issues like poverty-induced mental illness, ostracization of mentally ill individuals, and inadequate support from healthcare providers. The government's healthcare provisions largely overlooked mental health, with only a small portion of mental health policies being implemented and no regular public funding for these initiatives.

Despite mental health being recognized as a primary healthcare concern, access to mental health services remained limited, with only about 25% of the population having access. The lack of adequate treatment facilities and pervasive social stigma further impeded progress in addressing mental health issues.

A.2. Mental Healthcare for Host Ecuadorians and Venezuelan Refugees

Implementing mental healthcare in Ecuador for both host Ecuadorians and Venezuelan refugees involves addressing diverse challenges and needs. The influx of over 7 million Venezuelan refugees since 2015, due to the collapse of Venezuela’s economy, has significantly impacted Ecuador, which is now a major host country. These refugees face the trauma of displacement and the stress of rebuilding their lives in a new setting, leading to a high prevalence of mental health issues. Research collaborations in Ecuador, such as the one led by Columbia Mailman faculty, are exploring ways to support Venezuelan refugees by focusing on mental health and economic livelihoods. These efforts acknowledge the interconnection between economic stability and mental health outcomes.

Ecuador's approach towards mental healthcare for its host population has evolved over time. Traditionally, mental health was a neglected area, with limited access to services and inadequate implementation of mental health policies. However, recent developments include the enactment of a Mental Health Law, focusing on the overall well-being of individuals, and addressing physical, psychological, cognitive, emotional, and relational aspects of mental health. This law aims to prevent morbidity, mortality, discrimination, disability, and institutionalization through timely and preventive care, treatment, and rehabilitation, while also emphasizing the reduction of stigma around mental health.

The integration of economic and mental health services is crucial for supporting the lives and livelihoods of both Ecuadorians and Venezuelan migrants. This is a demonstration project to study the feasibility and preliminary effectiveness of Interpersonal Psychotherapy (IPT) for depressed host Ecuadorians and adult Venezuelen refugees who settled in Ecuador.

A.3. Why Interpersonal Psychotherapy (IPT)?

IPT is an evidence-based therapy that has shown effectiveness in treating depression and, most recently, post-traumatic stress disorder (PTSD) in numerous clinical trials. It has been tested in individual and group formats, in community and primary care settings, with adolescents and adults, including pre-and post-partum women, and the elderly. IPT in group and individual formats has shown effectiveness for persons exposed to extreme adversities following conflict and disasters. It was found to be highly effective in depressed adults affected by extreme adversity in southern Uganda. A number of psychotherapy capacity-building initiatives in low- and middle-income countries (LMICs) use IPT, most notably in Lebanon (in partnership with the Ministry of Public Health), Colombia (in partnership with the Ministry of Health), and Haiti (within the healthcare pyramid of Partners in Health). Among scalable psychological interventions, IPT is eminently suitable for refugees because: (1) it targets mental health conditions relevant to humanitarian settings , i.e., depression and PTSD; 2) it focuses on problem areas highly relevant to the experiences of displaced populations (e.g. grief, role transition, interpersonal conflict and social isolation); and (3) it is currently one of the only publicly available, standardized, and scalable psychological interventions which provides opportunities for rapid scaling up.

IPT is recommended by the World Health Organization (WHO) and mhGAP Humanitarian Intervention Guide as a first-line of treatment for depression in LMICs, and is currently rolled out by the UNHCR in refugee operations as a scalable intervention for depression for populations living in adversity. In October 2016, the Group IPT manual, of which Verdeli was the lead author, was jointly developed by Columbia University, and disseminated globally online by the WHO in several languages including Spanish.

A.4 Principles and Delivery of IPT

The basic idea of IPT is that there is a relationship (connection) between a person's mood and their interpersonal relationships. Triggers for periods of depression are often interpersonal difficulties. IPT recognizes four categories of interpersonal difficulties associated with the onset and persistence of depression as IPT problem areas: grief, disputes, life changes and loneliness/social isolation. Not everyone who struggles with problems will definitely develop depression. However, years of studies on the impact of life events on health show that these problem areas significantly increase a person's chances of developing depression.

Grief – Death of someone significant to the person (e.g. death of a child, spouse, parent or another family member)

Depressive symptoms may start around the time or shortly after the death of a loved one or of someone who has played an important role in the person's life. In some cases, the person may have had a complicated or difficult relationship with the person who has died. In normal grief, grief reactions that may look like depressive symptoms usually go away within a few months. Although the person needs support from family and/or community members, Group IPT may not be needed in normal grief. However, when symptoms persist and affect the person's ability to function, then the person may have depression and, if so, could benefit from Group IPT. *In the case of grief, the goals of therapy are to help the person mourn the loss of the loved one and to find other activities, social roles and people who will help to make life better.*

Disputes – Disagreements with someone in the person's life

The people involved can be fighting openly, or they may never acknowledge the conflict, however significant. For example, a husband wants more children but his wife does not, a neighbor is stealing but the victim cannot prove it, a person's boss gives a better job to someone else who has only recently been hired and the person believes that this is unfair. Depressive symptoms can be connected to an ongoing disagreement with someone important in the

person's life. The disagreement usually has to do with different expectations and communication problems between the person and the other party. The person has doubts that the disagreement can be resolved. Disputes can be obvious – when people argue openly – but also hidden, when they do not argue openly about the issue but are very distant and cold. *In the case of disputes, the goals of therapy are to help the person figure out what they and the other party want and expect, to develop new skills for communicating effectively with the other party, to practice those skills and to mobilize people who can help bring about a resolution of the conflict.*

Life Changes – Changes in a person's life or expectation of changes, negative or even positive, which influence personal relationships

Examples of life changes include: a woman getting married and moving to a new home, a spouse who wants to separate, a person learning that they have a serious illness, caring for someone who is dying, moving away from the family, retiring, marriage, childbirth, poverty after the death of a household earner, separation or rejection by a lover, or becoming a refugee. Life changes may include chronic situations such as poverty, either when the person's situation has become worse because of circumstances, or it is not improving despite the person's hopes. In this problem area, depressive symptoms occur around the time of a life change that affects the person's roles and interpersonal life. The person is having difficulty managing the situation and does not feel prepared for what has happened or is going to happen. *In the case of life changes, the goals of therapy are to help the person recognize that they are experiencing feelings such as sadness and anger, confusion or powerlessness about the change; examine what is positive about the change or its potential for growth and meaning; learn the skills necessary to manage the change; and find support to make the change easier.*

Loneliness/Social Isolation – Longstanding feelings of loneliness, boredom and/or emotional distance from others

The person has a history of problems in beginning or maintaining relationships with friends, relatives or others. The person talks about feeling lonely and separate from others. Although these feelings are longstanding, they may become worse after one of the other problems surfaces (such as a move to a different town for a new job, or the death of a friend or relative who used to be central in bringing people together socially). *In the case of loneliness/social isolation, the goals are to help the person find out what contributes to their loneliness and guide them to make friends by learning how to begin and maintain friendships.*

In Group IPT (IPT-G), facilitators help group members to find links between depression and current life problems, and to build communication and other interpersonal skills to manage their problems more effectively. The interpersonal nature of the group and the conversations within the group are helpful parts of this process, because this is where group members learn and where they get ideas on how to address their problems. Once the person has an idea about how to address the problem, they are encouraged to try it out and then discuss the results in the following session. This may help the person and other group members come up with more helpful ideas.

In summary, IPT-G focuses on:

- the current depression;
- the links between the person's depression and current problems that influence relationships; and
- finding new ways to deal with these problems.

Delivery Structure of IPT-G

In the current project, there were usually 4–8 members (women) per group and each session lasts 90 minutes. The group facilitator and all group members should speak the same language. All members who enrolled in IPT-G had depression. The depression was identified by an independent evaluator of the study using the PHQ-9. While Group IPT is not appropriate for people who have plans to end their lives in the near future (these persons immediately need more specific help), if participants have thoughts of ending their lives but have made no plans or recent attempts, they were allowed to participate in IPT-G. Similarly, people who have severe impairments

related to other mental, neurological or substance use disorders (e.g. psychosis, harmful use of alcohol or drugs, severe intellectual disability, dementia) were not enrolled in IPT-G for depression. IPT-G was also delivered in a multiphasic structure. The table below shows the phases of the group and its lengths.

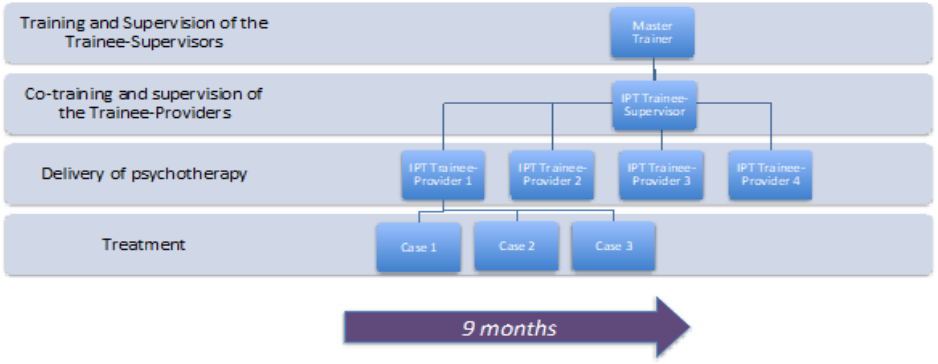
Phases	Sessions	Ideal frequency & length
Pre-group Phase	An individual session with each prospective group member	Once, 90 minutes
Initial Phase	Sessions 1 & 2	Weekly sessions, 90 minutes each
Middle Phase	Sessions 3 to 10 (8 group sessions)	
Termination Phase	Sessions 11 & 12 (final group sessions)	

B. <u>Project Goals</u>

Specific aims and deliverables:

1. Train and evaluate Vida Plena providers to become competent IPT providers (first generation of providers henceforth refered to as G1) (see Figure 1 below).
    a. *Deliverable:* Basic 4-day training of recruited trainees and providers in the 12-16 session format of IPT.
    b. *Deliverable:* Monitoring of IPT providers' competency levels through 2 cases of individual IPT and 1 group of IPT-G.
2. Train and evaluate Vida Plena providers to become competent IPT providers (second generation of providers henceforth refered to as G2).
    a. *Deliverable:* Basic 4-day training of recruited trainees and providers in the 12-16 session format of IPT.
    b. *Deliverable:* Monitoring of IPT providers' competency levels through 2 groups of IPT-G.
3. Train and evaluate G1 providers to become competent IPT supervisors.
    a. *Deliverable:* Monitoring of IPT supervisors' competency levels through supervising 2 groups of IPT-G for each G2 provider .
4. Evaluate patient-level outcomes at baseline, interim, and termination of patients receiving IPT (i.e., symptom reduction, improvement in functioning and wellbeing), as well as provider-level competence of IPT adoption and practice
    Deliverable: Systematic session-by-session monitoring of patients' treatment response, and evaluation of pre- and post-treatment clinical and functional status.

Figure 1. *Apprenticeship Model for IPT*



C. IPT Training

Providers were trained up to reach the benchmark of competence levels of IPT providers. The training followed an apprenticeship model developed by the PI of the project (Verdeli, 2003; Murray et al., 2011).

For the G1 IPT supervisors, the modified training completion criteria to be considered a competent supervisor are as follows:

1. Already met the IPT provider criteria and deemed competent in providing IPT.
2. Co-train IPT trainee-provider (G2) during the Initial Training Workshop, together with the master trainers.
3. Attendance in the weekly 90-minute group supervision of supervision sessions (≥75% attendance).
4. Attendance at the advanced IPT training workshop (4 months after initial didactics training).
5. Supervised (under master trainer supervision) at least 2 IPT-G patient groups (of 4-8 patients each).
6. Attaining competency as evaluated by the master trainers during the latter's supervision of the trainee-supervisors' supervision.

For the G2 IPT trainee-providers, the modified training completion criteria to be considered an IPT provider is per below:

1. Attendance of the initial didactics IPT-G training workshop
2. Passing the IPT-G Knowledge Test (≥75% questions answered correctly; trainee can take the test the second time if performance on first attempt is poor).
3. Attendance of the weekly hour-long supervision sessions (≥75% attendance)
4. Providing IPT-G to 2 patient groups (of 4-8 patients each)
5. Attaining competency on ≥70% performance benchmarks per the IPT-G competency checklist (as evaluated by the G1 supervisors using the supervision checklist)

IPT Training Strategies. In both, the initial IPT training and advanced workshop, high standards for experiential learning strategies and critical teaching methods were used.

***Experiential learning*:**

- Case demonstration where one trainer acts as the therapist and the other acts as a patient.
- Role-play with the trainer where the trainer acts as a depressed patient, and the trainees act as the therapist (initially collaboratively to make role-play safer and subsequently taking turns).
- Role-play in dyads for the pre-group individual meetings and in groups for the group session simulations.
- Teaching and co-teaching sessions of the training workshop program to peers, or trainee-supervisors.

Modeling:

Modeling is an important aspect of the IPT training, as it occurs on two levels:

1. The master trainers model how to conduct the didactic workshop, supervise, and support for the IPT-G trainee-supervisors.
2. Master trainers model how to deliver IPT-G through role-plays.

Feedback and coaching:

- During the role-play in dyads, the master trainers observe the practice, praise the good work and/or give constructive feedback.

***Critical Teaching (ABC Lesson Plan)* strategies involved:**

- **Anticipation:** The anticipation phase consisted of calling out existing knowledge, and the use of initial role-plays. Issues around mental health literacy and stigma are discussed in detail within the context of the low SES population in Ecuador, and are informed by the trainees' previous experience. The local relevance of the concepts and strategies was explored.

- **Building Information:** The powerpoint presentation and case demonstration in all problem areas covered in IPT, and real case examples brought by the trainers were used to build information.

Consolidation: Information was consolidated through group activities and co-teaching with the trainer. During the group activities involving role-plays, the trainees are encouraged to reflect on which IPT techniques they found the most useful, when, and which techniques resonated the least with them.

Knowledge Test: All providers passed the knowledge test in their first attempt with an average post-workshop score of 91% (82-98%).

Supervision
The supervision structure for IPT (and IPT-G) in this project followed the three-tier apprenticeship model articulated by Dr. Verdeli and elaborated upon by other investigators (Verdeli et al., 2003; see also Murray et al., 2011; Verdeli et al., 2016). In this model, the G2 providers provide mental health intervention to participants under the supervision of G1 supervisors (trainee-supervisors) who have reached competency in both the IPT-G model and supervisory skills. Master trainer Dr. Cheng completes the final tier of this model, providing supervision to the G1 supervisors by means of weekly, 1.5-hour clinical supervisory calls.

During the weekly supervision calls, G1 supervisors have been reporting on the attendance of the G2 providers and their patients. They also have been reviewing the clinical progress notes and the PHQ-9 scores of the patients, documented by the G2 providers. The G1 supervisors, together with the master trainer also evaluated competency of each G2 provider based on the IPT-G Competency Checklist based on the weekly progress notes and tasks reported to have been carried out by the G2 providers in their groups. This evaluation continued across all groups for each G2 provider. At the end of the phase, all G2 providers were deemed to have met the minimum provider competency levels for group IPT provision.

D. Preliminary Results

D.1 Results of Supervision and Clinical Outcomes of IPT Training Cases For G1
Three supervisory groups were formed, led by Dr. Bryan Cheng. All groups met weekly. Following the IPT didactic workshop, 100% of providers (4/4) were retained in supervision. All 4 met the required attendance record of ≥75% of supervision sessions.

In addition to the IPT skills, the providers learned to methodically document patients' progress and response to treatment as well as flag elevated risks (clinical, such as suicidality, or psychosocial, such as domestic abuse).

All 4 G1 providers met the IPT adherence benchmark by their second individual case (≥70% of the IPT competency checklist marked as or above "satisfactory"). The providers went on to complete their "3rd case" which was a group of at least 3-5 participants. There were high levels of enthusiasm about the treatment and engagement - providers frequently requested supplemental clinical and research articles, contributed to supervision with comments and follow-up questions, and supported each other during the entire training.

A total of 25 patients received IPT as training cases. Of these, over 75% of them met criteria for remission or response per the PHQ-9 by termination of IPT. **These preliminary results are especially encouraging given the complexity of patient presentation.** The majority of training cases screened positive for multiple disorders at baseline.

D.2 Results of Supervision and Clinical Outcomes of IPT Training Cases For G2

Descriptives - The most frequently observed category of Gender was 1 (*n* = 51, 76.12%). The most frequently observed category of Marital_Status was 1 (*n* = 33, 49.25%). The most frequently observed category of Nationality was 1 (*n* = 37, 55.22%). The most frequently observed category of Children was 1 (*n* = 43, 64.18%). The most frequently observed category of Main_provider was 0 (*n* = 38, 56.72%). The most frequently observed category of Education was 3 (*n* = 27, 40.30%).

The observations for Age had an average of 36.67 (*SD* = 14.27, SE_M = 1.84). The observations for Num_of_Children had an average of 2.19 (*SD* = 1.33, SE_M = 0.21). The observations for Household_Size had an average of 3.92 (*SD* = 1.90, SE_M = 0.25).

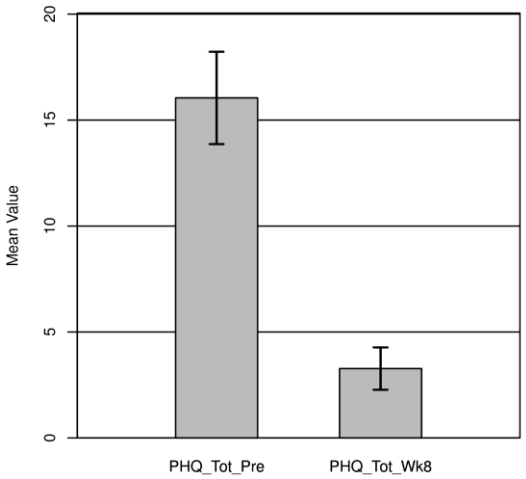
PHQ-9 Changes from Pre- to Termination - The result of the two-tailed paired samples *t*-test was significant based on an alpha value of .05, *t*(21) = 10.25, *p* < .001, indicating the null hypothesis can be rejected. This finding suggests the difference in the mean of PHQ_Tot_Pre and the mean of PHQ_Tot_Wk8 was significantly different from zero. **The mean of PHQ_Tot_Pre was significantly higher than the mean of PHQ_Tot_Wk8.** The results are presented in Table 1. A bar plot of the means is presented in Figure 2.

Table 1. *Two-Tailed Paired Samples t-Test for the Difference Between PHQ_Tot_Pre and PHQ_Tot_Wk8*

PHQ_Tot_Pre		PHQ_Tot_Wk8				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
16.05	5.21	3.27	2.39	10.25	< .001	2.18

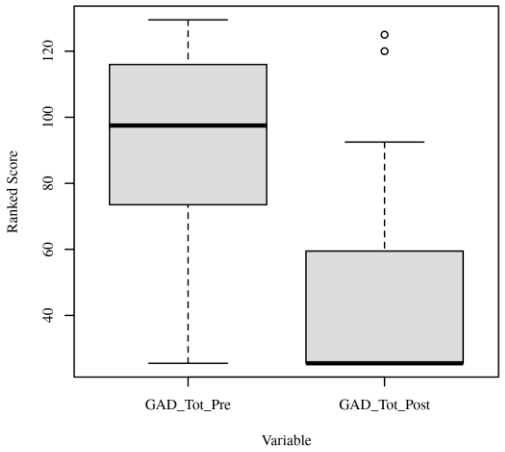
Note. N = 22. Degrees of Freedom for the *t*-statistic = 21. *d* represents Cohen's *d*.

Figure 2. *The means of PHQ_Tot_Pre and PHQ_Tot_Wk8 with 95.00% CI Error Bars*



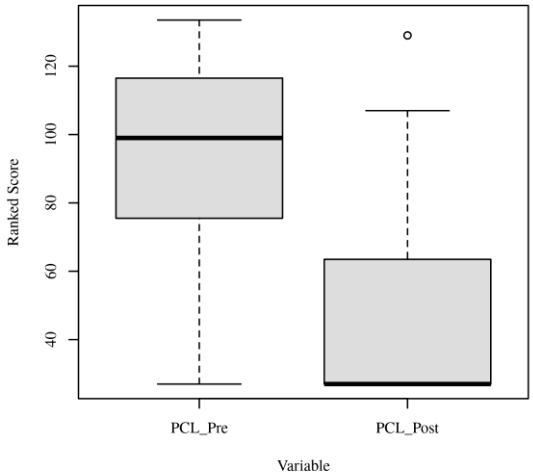
GAD-7 Changes from Pre- to Termination - The results of the two-tailed Wilcoxon signed rank test were significant based on an alpha value of .05, *V* = 1,528.00, *z* = -5.96, *p* < .001. This indicates that the differences between GAD_Tot_Pre and GAD_Tot_Post are not likely due to random variation. **The median of GAD_Tot_Pre (*Mdn* = 12.50) was significantly larger than the median of GAD_Tot_Post (*Mdn* = 0.00).** Figure 3 presents a boxplot of the ranked values of GAD_Tot_Pre and GAD_Tot_Post.

Figure 3. *Ranked values of GAD_Tot_Pre and GAD_Tot_Post*



PCL Changes from Pre- to Termination - The results of the two-tailed Wilcoxon signed rank test were significant based on an alpha value of .05, $V = 1{,}712.00$, $z = -6.24$, $p < .001$. This indicates that the differences between PCL_Pre and PCL_Post are not likely due to random variation. **The median of PCL_Pre (*Mdn* = 45.36) was significantly larger than the median of PCL_Post (*Mdn* = 0.00).** Figure 4 presents a boxplot of the ranked values of PCL_Pre and PCL_Post.

Figure 4. *Ranked values of PCL_Pre and PCL_Post*



PHQ-9 Change over Time - The results were examined based on an alpha of .05. The *p*-values for the within-subjects factor and the interactions with the within-subjects factor were calculated using the Greenhouse-Geisser correction to adjust for the violation of the sphericity assumption. According to Greenhouse and Geisser (1959), this is the appropriate way to adjust for violations of the sphericity assumption. The main effect for the within-subjects factor was significant, $F(4, 40) = 26.98$, $p < .001$, indicating there were significant differences between

the values of PHQ_Tot_Pre, PHQ_Tot_Wk1, PHQ_Tot_Wk4, PHQ_Tot_Wk6, and PHQ_Tot_Wk8. Table 3 presents the ANOVA results. The means of the within-subjects factor are presented in Table 4 and Figure 5. **Significant reductions in PHQ-9 scores were observed between pre- and Week 4 onwards, Week 1 and Week 6 onwards, as well as between Week 6 and Week 8.**

Table 3. *Repeated Measures ANOVA Results*

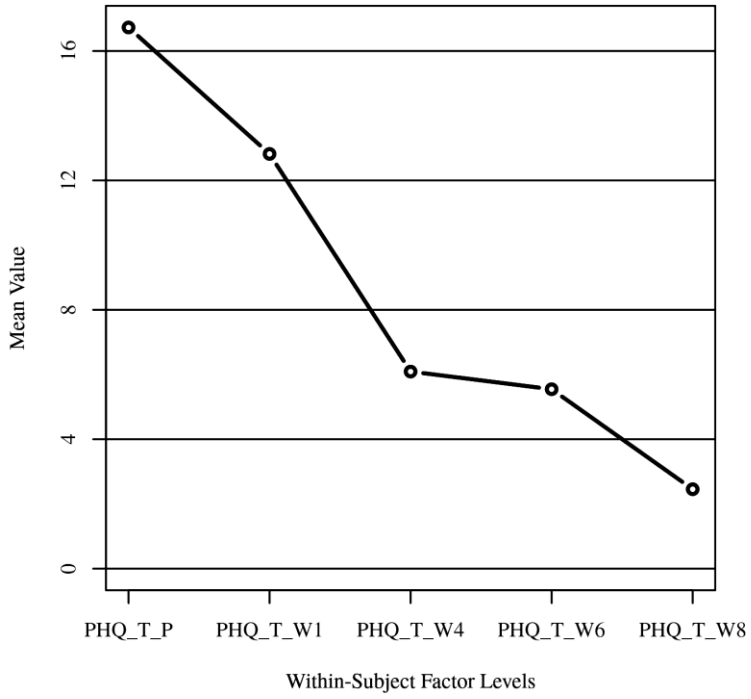
Source	*df*	*SS*	*MS*	*F*	*p*	η_p^2
Within-Subjects						
Within Factor	4	1,508.73	377.18	26.98	< .001	0.73
Residuals	40	559.27	13.98			

Table 4. *Means Table for Within-Subject Variables*

Variable	*M*	*SD*
PHQ_Tot_Pre	16.73	5.18
PHQ_Tot_Wk1	12.82	6.69
PHQ_Tot_Wk4	6.09	4.39
PHQ_Tot_Wk6	5.55	3.78
PHQ_Tot_Wk8	2.45	2.16

Note. $n = 11$.

Figure 5. *Within-subject variable means*



Despite the difficult circumstances and high comorbidity (including suicidal ideation), results of this program indicate that host Ecuadorians and Venezuelan refugees responded well to IPT. These results point to the high acceptability and feasibility of this approach in treating depression and other common mental disorders in this setting. They are especially significant given that the social determinants of depression in the hosts and refugees' lives in Ecuador not only did not improve during the life of the project but have been deteriorating, with enormous added burdens imposed by the pandemic.

Currently, the providers, the Vida Pena team, and the master trainers are in the process of planning an edited volume of IPT case studies for refugees in Ecuador.